(X6) DATE:

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395295		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/19/2023	
NAME OF PROVIDER OR SUPPLIER: MURRYSVILLE REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: 134702			STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	OAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0000	Based on a Medicare/N Survey, Civil Rights Continuous Electronic Survey and a response to two complations of two complations and Well Compliance with the resultance with the resultance of the Assample of th	ompliance Survey, San Abbreviated survenints, completed on a different that Murrysville liness Center, was not quirements of 42 CF rements for Long-Term Care Licensure	State ey in April 19 ot in FR Part erm Care ealth of	F 0041	TITLE:	(X6) DATE:	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBER 395295		A. BLDG: _	_00	(X3) DATE SURV COMPLETED: 04/19/2023		
MURRYS' WELLNES	OVIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER	N AND	STREET ADDRESS 3300 LOGAN MURRYSVI	NS FERRY R	OAD			
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE .	OULD BE	(X5) COMPLETE DATE	
F 0641 SS=D	Continued from page 1 483.20(g) Accuracy of Asset §483.20(g) Accuracy of Asset The assessment must accura status. This REQUIREMENT is not	sessments. ately reflect the resident	's	F 0641	The facility will ensure that Data Set (MDS) assessment accurately reflect the resider status for all residents. Residents. Residents accurately reflect resident swallowing/nutritional status accurately. The Dietitian or designee with complete a house audit of resection K of MDS assessments accurately reflected. The Regional Dietitian Considering will reeducate register that their swallowing/nutritional status accurately reflected. The Regional Dietitian Consideritian on facility's MDS/F Planning policy and how to accurately complete Section MDS assessments. The Dietitian or designee with to ensure new admissions ar residents with change of conwill have an accurate Section MDS assessments to ensure swallowing/nutritional status	ts nt's dent s updated t's s updated t's s ill sidents' ents to s is sultant or stered RAI Care K of ill audit ad adition n K of that	Completion Date: 05/23/2023 Status: APPROVED Date: 04/28/2023	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395295		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/19/2023	
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER E NUMBER: 134702	NAND	STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	OAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0641 SS=D	Continued from page 2			F 0641	accurately reflected. These a will be completed 3x weekly weeks and then monthly for months. These audits will be forward monthly Quality Assurance a Performance Improvement Committee for review, recommendations, and frequaudits.	of for four three ed to and	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395295		1	00	04/19/2023	
NAME OF PROVIDER OR SUPPLIER: MURRYSVILLE REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: 134702			STREET ADDRESS, 3300 LOGAN; MURRYSVIL	S FERRY R	OAD		
(X4) ID PREFIX TAG	REFIX MUST BE PRECEEDED BY FULL REGULATORY OF			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0641	Continued from page 3		F 0641				
SS=D	Based on review of the Instrument (RAI) user' for completing Minimulassessment of care neel records and staff intervithe facility failed to en (MDS- periodic assess assessments accurately for one of three residers. The RAI User's Manual indicated Section K, K do not code a swallowing interventions have been problem (K0100A three during the 7-day look-labeled A review of facility por Planning" dated 2/22/2 discipline of the interdirect.	s manual (gives instant Data Set - period ds), facility policy, oriew, it was determine sure that Minimum I ment of care needs) reflected the residents (Resident R31). Al, dated October 20: (20100: Swallowing I ing problem when in successful in treating the sign/symptoms of back period. Alicy "MDS/RAI/Care 33, indicated that each	ructions lic clinical ned that Data Set nt's status 19, Disorder ng the of the ot occur				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395295			<u></u>	04/19/2023	
NAME OF PROVIDER OR SUPPLIER: MURRYSVILLE REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: 134702			STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	OAD		
(X4) ID PREFIX TAG	EFIX MUST BE PRECEEDED BY FULL REGULATORY OR LSC			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0641 SS=D	responsible to sign the certify that his/her sect A review of the clinical Resident R31 was admited with diagnosis that incompared with diagnosis that incompared here. The subarachnoid space, and the tissue covering the with difficulty in swall cerebral infarction (refibrain due to a loss of of quadriplegia (a conditional legs are paralyzed). A review of Resident Frances assessment (MDS-Min periodic assessment of 2/1/23, indicated that direview. A review of the recapital as of 4/18/23, indicated that direview.	il face sheet indicate atted to the facility 2 luded non-traumatic age (bleeding within a area between the brain), dysphagia (a owing food or liquiders to damage to tiss xygen to the area), a on where both the area at the	the rain and condition of following rues in the rand rms and condition of the rain and	F 0641			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395295				04/19/2023	
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER SE NUMBER: 134702	N AND	STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	COAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 5 (nothing by mouth, a n withhold food and fluid Further review of clinic initiated 2/10/15, revise Resident R31 is depend of delivering nutrition small intestine) related inability to meet needs Interview conducted on Registered Nurse Emp Resident R31 is NPO (been since admission to Further review of Resident R31 is NPO (been since admission to Symptoms of possible Check all that apply: K0100A. Loss of liquid eating or drinking was K0100B. Holding food	cal records current ced 2/21/23, indicated dent on tube feeding directly to your ston to chronic dysphagical via oral (by mouth) in 4/18/23, at 10:15 at loyee E11 confirmed nothing by mouth), to facility. dent R31's Quarterly 3, indicated the follog Disorder, Signs and swallowing disorder ds/solids from mouth checked/coded with	are plan, d s (a way nach or ia and means. h.m., d that and has y MDS owing: d r h while a a "X"	F 0641			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395295				04/19/2023	
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER SE NUMBER: 134702	N AND	STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	COAD		
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY (TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0641	Continued from page 6	ued from page 6		F 0641			
SS=D	food in mouth after me a "X" K0100C. Coughing or when swallowing med with a "X" K0100D. Complaints of swallowing was checked. Review of clinical recordance of the control of the contr	choking during mealications was checked of difficulty or pain ved/coded with a "X" ords, Nutrition Statu /23, indicated resided reside	als or d/coded with s Review ent R31 Diet/Meal review of to sorder rterly 2/1/23. , at 10:00 confirmed sment ed in				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395295				04/19/2023	
NAME OF PROVIDER OR SUPPLIER: MURRYSVILLE REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: 134702			STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	OAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0641	Continued from page 7			F 0641			
SS=D	through K0100D).	anducted on 4/10/23	at 0:45				
	During an interview conducted on 4/19/23, at 9:45 a.m., Registered Nurse Assessment Coordinator (RNAC) Employee E13 confirmed that Resident R31's Quarterly MDS assessment, dated 2/1/23,						
	Section K0100, was co facility failed to ensure						
	accurately reflected the three residents (Reside	e resident's status for					
	28 Pa. Code: 211.12 (d	1)(1)(2)(5) Nursing s	ervices.				
F 0657				F 0657			
SS=D							

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	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395295		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/19/2023	
MURRYS' WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER		STREET ADDRESS. 3300 LOGAN MURRYSVIL	S FERRY R	OAD		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOLS DEPEND TO THE	OULD BE	(X5) COMPLETE DATE
TAG	IDENTI	FYING INFORMATION)			CROSS-REFERENCED TO THE A	APPROPRIATE	DATE
F 0657	Continued from page 8			F 0657			
SS=D							
	§483.21(b) Comprehensive §483.21(b)(2) A comprehen (i) Developed within 7 days comprehensive assessment. (ii) Prepared by an interdisc is not limited to (A) The attending physician (B) A registered nurse with (C) A nurse aide with respo (D) A member of food and a (E) To the extent practicable resident and the resident's re explanation must be include if the participation of the re- representative is determined development of the resident (F) Other appropriate staff of determined by the resident's resident. (iii)Reviewed and revised b each assessment, including	 (ii) Prepared by an interdisciplinary team, that includes but is not limited to (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the 			The facility will ensure that plans for all residents are revised/updated to accurately the current status of the resident R55's care plan was updated to accurately reflect resident's significant weight use of oral nutritional supple. The Director of Nursing or a will complete a house audit residents' care plans with a significant weight loss or rescurrently using oral nutrition supplements to ensure that the plans accurately reflect the restatus. The Director of Nursing or a will reeducate licensed nurse including agency and new his facility's MDS/RAI Care Plapolicy and the requirement for care plans to accurately reflected resident's status.	y reflect dent. ss t the loss and ements. designee of sidents heir care residents' designee es, ires, on anning for the ect the	Completion Date: 05/23/2023 Status: APPROVED Date: 04/28/2023
					The Director of Nursing or c will audit to ensure new adm and residents with change of	nissions	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

	OF DEFICIENCIES AND RECTION (POC)	identification number 395295		A. BLDG: _	00	COMPLETED: 04/19/2023		
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER SE NUMBER: 134702	N AND	STREET ADDRESS. 3300 LOGAN MURRYSVIL	S FERRY R	OAD			
(X4) ID PREFIX TAG	REFIX MUST BE PRECEEDED BY FULL REGULATORY TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOREST CROSS-REFERENCED TO THE ACTION OF T	OULD BE	(X5) COMPLETE DATE	
F 0657 SS=D	Continued from page 9		F 0657	condition related to significate weight loss and the use of or nutritional supplements will updated care plan to accurate reflect the residents' status. The audits will be completed 3x for four weeks and then more three months. These audits will be forward monthly Quality Assurance and Performance Improvement Committee for review, recommendations, and frequaudits.	ral have an ely These weekly athly for led to and			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395295			00	04/19/2023	
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER	N AND	STREET ADDRESS, 3300 LOGAN; MURRYSVIL	S FERRY R	OAD		
(X4) ID	E NUMBER: 134702 SUMMARY STATEMENT	OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE IDENTII	R LSC	PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE .	OULD BE	COMPLETE DATE	
F 0657	Continued from page 10	ontinued from page 10		F 0657			
SS=D	Based on review of fac	cility policy clinical	records				
	and staff interview, it v		•				
	failed to revise/update	care plans for one of	f five				
	residents to accurately	reflect the current st	atus of				
	the resident (Resident R55).						
	Findings include:						
	A review of facility po	licy "MDS/RAI/Car	e				
	Planning" dated 2/22/2	3, indicated that the	Resident				
	Assessment Instrument	t (RAI) and Care Pla	nning				
	Process provide a tool	-	-				
	approach to plan the ca						
	will have a comprehen						
	day 14 of stay and a Co	-					
	completed and reviewe completion date of the						
	be assessed at least qua						
	reviewed by the interdi	-					
	OBRA schedule and m		•				
	Medicare reimburseme						
	A review of the clinica	l face sheet indicate	d that				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395295			<u>vv</u>	04/19/2023	
MURRYSV WELLNES STATE LICENS	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER SE NUMBER: 134702		STREET ADDRESS, 3300 LOGAN MURRYSVIL	S FERRY R	OAD 668		/V5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENC MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0657 SS=D	Resident R55 was adm with diagnosis that includencer, and rectal cancer. A review of Resident F assessment (MDS-Min periodic assessment of 3/3/23, indicated that direview. A review of Resident F dated 1/19/23, Section coded as a "2, yes, not weight-loss regimen", 5% or more in the last more in last 6 months. Further review of Resident F dated 3/3/2 Loss was coded as a "2 physician-prescribed windicated significant w last month or loss of 10	lude bacterial infectiver. R31's Quarterly MDS asserting immum Data Set asserting immum Data Se	ssment: dated rent upon sessment s was ibed ght loss of or MDS Veight , which more in the	F 0657			

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	OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C RECTION (POC) IDENTIFICATION NUMBER:				IPLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED:	EY
		395295		A. BLDG: _ B. WING: _	_00	04/19/2023	
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION S CENTER E NUMBER: 134702	N AND	STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	OAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0657	Continued from page 12			F 0657			
SS=D							
	A review of Resident R	R31's clinical record,	Nutrition				
	Status Review - Quarte	erly, dated 3/4/23, in	dicated				
	a significant decrease of		-				
	days. Recommendations were made to begin						
	nutritional treat twice a	a day with lunch and	dinner.				
	A review of Resident F	R31's clinical record,	active				
	physician orders as of	4/18/23, indicated th	at				
	Resident R55 is ordere	d Nutritious Treat C	up two				
	times a day with lunch	and dinner, initiated	1 3/7/23,				
	and Nutritious Shake w	with meals, initiated	4/10/23.				
	A review of Resident F	R31's current care pla	an failed				
	to indicate goals and in	•					
	weight loss, and failed						
	supplement (Nutritious	-					
	Shakes) as intervention	is for nutritional pro	blems.				
	During an interview co	onducted 4/19/23, at	9:45				
	a.m., RNAC Employee	E13 confirmed that	the				
	facility failed to revise	update the care plan	to .				
	accurately reflect the co	urrent status of Resi	dent				

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	TEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER (XI) PROVIDER (XI) PROV			(X2) MULTIPLE CONSTRUCTION: A. BLDG: _00		(X3) DATE SURVEY COMPLETED:	
		395295			<u>vv</u>	04/19/2023	
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER	I AND	STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	OAD		
STATE LICENS (X4) ID	E NUMBER: 134702 SUMMARY STATEMENT	OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (FACH	(X5)
PREFIX TAG	MUST BE PRECEEDE	ED BY FULL REGULATORY OF FYING INFORMATION)		PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	COMPLETE DATE
F 0657	Continued from page 13			F 0657			
SS=D	R55's significant weigh	nt loss and use of ora	n1				
	nutritional supplements		••				
	28 Pa. Code: 211.11(d) Resident care plan.						
	28 Pa. Code: 211.12(d)	(5) Nursing services	S.				
F 0684				F 0684			
SS=D							

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/GIDENTIFICATION NUMBER 395295		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURV COMPLETED: 04/19/2023	ΈΥ
MURRYS' WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER		STREET ADDRESS 3300 LOGAN MURRYSVII	S FERRY R	OAD		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 14			F 0684			
SS=D	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundame treatment and care provided the comprehensive assessment assessment ensure that residents reaccordance with professions comprehensive person-centeresidents' choices. This REQUIREMENT is not	to facility residents. Basent of a resident, the faceceive treatment and caral standards of practice, ered care plan, and the	ased on cility re in		The facility will ensure that a physician is notified of abno glucose levels via a Capillary Glucose (CBG) level as per all residents who require CB testing. Facility notified atterphysician notification of abn blood glucose levels for residents and 3/20/23. The Director of Nursing or dwill complete a house audit of monitoring summaries for the thirty days for residents who CBG testing to ensure physical notifications were made for recorded to have abnormal beglucose levels. The Director of Nursing or dwill reeducate licensed nurse including agency and new his facility's "Notification of Chepolicy and requirement to no physician for all residents rector have abnormal blood glucolevels. The Director of Nursing or dwill residents rector have abnormal blood glucolevels.	rmal y Blood order for G nding formal dent R64 B designee of CBG te last require cian residents clood designee es, ires, on anges" otify corded	Completion Date: 05/23/2023 Status: APPROVED Date: 04/28/2023

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395295			00	04/19/2023	
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION S CENTER E NUMBER: 134702	N AND	STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	OAD		
(X4) ID PREFIX TAG	EFIX MUST BE PRECEEDED BY FULL REGULATORY OR			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 15			F 0684			
SS=D	Zolfu: Zoue: Zrinz(u) services.		The state of the s		will audit to review CBG me summaries for residents who CBG testing and ensure physical notifications are made when abnormal blood glucose lever recorded. These audits will be completed 3x weekly for four and then monthly for three numbers audits will be forward monthly Quality Assurance and Performance Improvement Committee for review, recommendations, and frequaudits.	o require sician an el is oe ur weeks nonths.	
F 0726				F 0726			
SS=E							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	ORRECTION (POC) IDENTIFICATION NUMBER: A. BLDG: _00 P. WING:		EY					
NAME OF PROVIDER OR SUPPLIER:	395295	STREET ADDRESS			04/17/2023			
MURRYSVILLE REHABILITATION	N AND	3300 LOGANS FERRY ROAD MURRYSVILLE, PA 15668						
WELLNESS CENTER		MUKKYSVIL	LE, PA 150	008				
STATE LICENSE NUMBER: 134702								
PREFIX MUST BE PRECEED!	F OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF IFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE		
F 0726 Continued from page 16			F 0726					
SS=E								
483.35(a)(3)(4)(c) Compete	ent Nursing Staff					Completion		
	§483.35 Nursing Services The facility must have sufficient nursing staff with appropriate competencies and skills sets to provide and related services to assure resident safety and att			The facility will complete tir		Date:		
				resident rights competencies		05/23/2023		
				facility staff. Resident rights		Status: APPROVED		
				competencies will be complete Employees E4 through E9.	eted for	Date:		
maintain the highest practic	-			Employees E4 unough E7.		04/28/2023		
psychosocial well-being of				The facility has scheduled a				
resident assessments and in				mandatory resident rights ins	service			
considering the number, act	-			for all facility staff, including	g agency			
facility's resident population	n in accordance with the	facility		and new hires, on May 4th to				
assessment required at §483	3.70(e).			facility staff is provided with	1			
				resident rights training and				
§483.35(a)(3) The facility r				competencies.				
have the specific competent care for residents' needs, as		-		The Nursing Home Adminis	trator or			
assessments, and described	_	511 t		Designee will re-educate the				
assessments, and described	mo pium of oute.			Resources Director, the facil				
§483.35(a)(4) Providing car	re includes but is not lim	ited to		staff education, on federal re				
assessing, evaluating, plann				0726, detailing providing fac	cility staff			
care plans and responding t	o resident's needs.			with timely required annual	resident			
				rights education.				
§483.35(c) Proficiency of n				TEL. NI	44			
The facility must ensure that				The Nursing Home Adminis	trator			
demonstrate competency in necessary to care for residen	-	hrough		will complete an audit of 10 personnel records weekly for	r four			
resident assessments, and d		-		weeks then monthly for three				
resident assessments, and u	esorioca in the plan of co			months to validate employee				
This REQUIREMENT is no	ot met as evidenced by:			received timely annual reside				
				rights education.				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	ΣΥ
		395295		B. WING: _		04/19/2023	
MURRYSV	VIDER OR SUPPLIER: VILLE REHABILITATION S CENTER	I AND	STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	OAD		
	E NUMBER: 134702						
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DEI ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0726	Continued from page 17			F 0726			
SS=E							
					The results of these audits we forwarded to the monthly Qu Assurance and Performance Improvement Committee for and frequency of audits.	ality	

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	NT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIED CORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395295		A. BLDG:00_ B. WING:			
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER SE NUMBER: 134702	N AND	STREET ADDRESS 3300 LOGAN MURRYSVII	S FERRY R	OAD		
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0726	Continued from page 18			F 0726			
SS=E	Based on review of fact and staff interview, it we failed to complete time competencies for six of personnel records (Nur NA Employee E5, NA Practical Nurse (LPN) Nurse (RN) Employee E9). Findings include: The facility "Staff dever 2/22/23, indicated that development and educated shall be ongoing coord which is planned and controlled to resident right mandatory in-services rights, privacy, and dig Review of NA Employ indicated she was hired	was determined that ely annual resident riut of seven sampled are Aide (NA) Employee E6, Lice Employee E7, Regis E8, and LPN Employee E8, and LPN Employees. Ination to employees. Ination of education conducted including ats. All employees re annually and including ty.	the facility ights oyee E4, nsed stered oyee of reviewed wide staff There program training ceive e resident				

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OF DEFICIENCIES AND RECTION (POC)	` /		A. BLDG: _	<u>00</u>	COMPLETED: 04/19/2023	5 Y
S CENTER	I AND	3300 LOGANS	S FERRY R	OAD		
SUMMARY STATEMENT MUST BE PRECEEDE	ED BY FULL REGULATORY O		ID PREFIX TAG	CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETE DATE
Review of NA Employ indicated she was hired Review of LPN Employ indicated he was hired Review of RN Employ indicated she was hired Review of LPN Employ indicated she was hired Review of LPN Employindicated she was hired Review of annual in-service on resident reservice on resident residuals.	ree E6's personnel red 7/3/17. yee E7's personnel red 10/27/19. ee E8's personnel red 8/30/11. yee E9's personnel red 17/24/06. ervices for NA Empl Employee E6, LPN ployee E8, and LPN include a 2022 annualights.	ecord record record oyee E4,	F 0726			
During an interview or	1 4/18/23, at 11:30 a.	.m. the				
	RECTION (POC) VIDER OR SUPPLIER: VILLE REHABILITATION IS CENTER E NUMBER: 134702 SUMMARY STATEMENT MUST BE PRECEEDE IDENTIFY Continued from page 19 Review of NA Employ indicated he was hired Review of LPN Employ indicated she was hired Review of RN Employ indicated he was hired Review of RN Employ indicated she was hired Review of LPN Employ indicated she was hired Review of IPN Employ indicated she was hired	RECTION (POC) IDENTIFICATION NUMBER 395295 VIDER OR SUPPLIER: TILLE REHABILITATION AND SCENTER E NUMBER: 134702 SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION) Continued from page 19 Review of NA Employee E5's personnel reindicated he was hired 6/4/91. Review of NA Employee E6's personnel reindicated she was hired 7/3/17. Review of LPN Employee E7's personnel reindicated he was hired 10/27/19. Review of RN Employee E8's personnel reindicated she was hired 8/30/11. Review of LPN Employee E9's personnel reindicated she was hired 7/24/06. Review of annual in-services for NA Employee E7, RN Employee E8, and LPN Employee E9 did not include a 2022 annual in-service on resident rights.	RECTION (POC) IDENTIFICATION NUMBER: 395295 VIDER OR SUPPLIER: 7ILLE REHABILITATION AND SCENTER ENUMBER: 134702 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 19 Review of NA Employee E5's personnel record indicated he was hired 6/4/91. Review of NA Employee E6's personnel record indicated she was hired 7/3/17. Review of LPN Employee E7's personnel record indicated he was hired 10/27/19. Review of RN Employee E8's personnel record indicated she was hired 8/30/11. Review of LPN Employee E9's personnel record indicated she was hired 7/24/06. Review of annual in-services for NA Employee E4, NA Employee E5, NA Employee E6, LPN Employee E7, RN Employee E8, and LPN Employee E9 did not include a 2022 annual	RECTION (POC) DENTIFICATION NUMBER: 395295 A. BLDG: B. WING:	RECTION (POC) DENTIFICATION NUMBER: 395295 A BLDG: 90 B WING:	IDENTIFICATION NUMBER 395295 A. BLDG: 60

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	DF DEFICIENCIES AND (XI) PROVIDER/SUPPLIE RECTION (POC) IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395295		B. WING: 04/19/2023			
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER E NUMBER: 134702	I AND	STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	OAD		
(X4) ID PREFIX TAG	FIX MUST BE PRECEEDED BY FULL REGULATORY C			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0726	Continued from page 20			F 0726			
SS=E	Director of Human Resconfirmed the facility of annual resident rights of Employee E4, NA Employee E7, F. Employee E9 as require 28 Pa. Code 201.20(a) of 28 Pa. Code: 207.2(a) of responsibility.	Failed to complete tine competencies for NA ployee E5, NA Emp RN Employee E8, and ed. (b)(d) Staff development of the competencies for NA ployee E5, NA Emp RN Employee E8, and ed.	mely A loyee E6 ad LPN ment.				
F 0732 SS=C				F 0732			

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	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			IPLE CONSTRUCTION:	(X3) DATE SURV COMPLETED:	EY
		395295			00	04/19/2023	
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER SE NUMBER: 134702	N AND	STREET ADDRESS 3300 LOGAN MURRYSVII	S FERRY R	OAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OR LSC TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0732	Continued from page 21			F 0732			
SS=C	483.35(g)(1)-(4) Posted Nurse \$483.35(g) Nurse Staffing I \$483.35(g)(1) Data requirer following information on a (i) Facility name. (ii) The current date. (iii) The total number and the following categories of licer staff directly responsible for (A) Registered nurses. (B) Licensed practical nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. \$483.35(g)(2) Posting requirent (i) The facility must post the paragraph (g)(1) of this sect beginning of each shift. (ii) Data must be posted as a (A) Clear and readable form (B) In a prominent place reavisitors. \$483.35(g)(3) Public access The facility must, upon oral staffing data available to the to exceed the community staffing data available to the content of the community staffing data available to the content of the community staffing data available to the content of the community staffing data available to the community staffing data available	nformation. nents. The facility must daily basis: ne actual hours worked to nsed and unlicensed nur resident care per shift: es or licensed vocational not. rements. e nurse staffing data spe tion on a daily basis at the follows: nat. ndily accessible to reside to posted nurse staffing or written request, mak e public for review at a ce	t post the by the sing nurses cified in ne ents and g data. e nurse		The facility will ensure currenursing staffing hours are posed a daily basis as required. Facinmediately posted current is staffing hours for 4/16 when identified by surveyor. The administrator or designere-educate the Human Resound Director/Scheduler on federa F-0732 and the requirement nursing staffing hours on a dibasis. The administrator or designere complete an audit 5x weekly weeks and monthly for three to ensure nursing staffing hoposted as required. These audits will be forward monthly Quality Assurance and Performance Improvement Committee for review, recommendations, and frequaudits.	ee will urces al tag to post daily ee will y for four e months ours are	Completion Date: 05/23/2023 Status: APPROVED Date: 04/28/2023

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER PLAN OF CORRECTION (POC) IDENTIFICATION NUMBE				PLE CONSTRUCTION:	COMPLETED:	
		395295		B. WING: _		04/19/2023	
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER	NAND	STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	OAD		
(X4) ID	E NUMBER: 134702	OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)			PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	COMPLETE DATE
F 0732	Continued from page 22			F 0732			
SS=C	§483.35(g)(4) Facility data facility must maintain the perfor a minimum of 18 month whichever is greater. This REQUIREMENT is not	osted daily nurse staffing s, or as required by State	g data				

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NAME OF PROVIDER OR SUPPLIER MURRYSVILLE REHABILITATION AND WELLAKES CENTER STATELETENS NUMBER 134702 OCH ID PREFIN TAG CONDITION MINT BE PRECEDED BY FULL REGILATORY OR ISC DESTINATION DESTINATION MINT BE PRECEDED BY FULL REGILATORY OR ISC DESTINATION DESTINATION SEMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MINT BE PRECEDED BY FULL REGILATORY OR ISC DESTINATION FOR 732 Continued from page 23 F 0732 SS=C Based on observation and staff interview, it was determined that the facility staff failed to display current nurse staffing hours on a daily basis as required. Findings include: During an entrance observation on Sunday 4/16/23, at 9:27 a.m. the Nursing Home Administrator confirmed the above observation and that the facility failed to display current nurse staffing hours on a daily basis as required. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1) Nursing services. F 0757 F 0757	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/A IDENTIFICATION NUMBER			(X2) MULT A. BLDG: _ B. WING: _		(X3) DATE SURVEY COMPLETED: 04/19/2023		
SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY PRETEX TAG PROVIDERS PLAN OF CORRECTION EACH CONFIDENTIFYING INFORMATION) PRETEX TAG CONFIDENTIFYING INFORMATION PRETEX TAG CONFIDENTIFYING CONFIDENTIFYING INFORMATION PRETEX TAG CONFIDENTIFYING CONFIDENTIFYING CONFIDENTIFYING CONFIDENTIFYING CONFIDENTIFYING CONFIDENTIFY IN THE APPROPRIATE CONFIDENTIFY ACTION SHOULD BE CONFIDENTIFY ACTION	MURRYSV WELLNES	VILLE REHABILITATION SS CENTER	395295 N AND	3300 LOGANS	S FERRY R	OAD		
Based on observation and staff interview, it was determined that the facility staff failed to display current nurse staffing hours on a daily basis as required. Findings include: During an entrance observation on Sunday 4/16/23, at 8:30 a.m. in the main entrance lobby, posted nurse staffing hours were dated Wednesday 4/12/23. During an interview on Sunday 4/16/23, at 9:27 a.m. the Nursing Home Administrator confirmed the above observation and that the facility failed to display current nurse staffing hours on a daily basis as required. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1) Nursing services.	(X4) ID PREFIX	SUMMARY STATEMENT MUST BE PRECEEDI	ED BY FULL REGULATORY O			CORRECTIVE ACTION SH	OULD BE	COMPLETE
Based on observation and staff interview, it was determined that the facility staff failed to display current nurse staffing hours on a daily basis as required. Findings include: During an entrance observation on Sunday 4/16/23, at 8:30 a.m. in the main entrance lobby, posted nurse staffing hours were dated Wednesday 4/12/23. During an interview on Sunday 4/16/23, at 9:27 a.m. the Nursing Home Administrator confirmed the above observation and that the facility failed to display current nurse staffing hours on a daily basis as required. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1) Nursing services. F 0757		Continued from page 23			F 0732			
		determined that the facturent nurse staffing required. Findings include: During an entrance obstat 8:30 a.m. in the main nurse staffing hours we 4/12/23. During an interview or a.m. the Nursing Home above observation and display current nurse star required. 28 Pa. Code 201.14(a)	servation on Sunday n entrance lobby, poere dated Wednesday A Administrator confithat the facility faile taffing hours on a date.	isplay is as 4/16/23, sted y 9:27 firmed the ed to aily basis	5.0757			
22-17	F 0757 SS=D				F 0757			

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395295		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURV COMPLETED: 04/19/2023	VEY
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER SE NUMBER: 134702	NAND	STREET ADDRESS 3300 LOGAN MURRYSVII	S FERRY R	OAD		
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY (TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0757	Continued from page 24			F 0757			
SS=D	483.45(d)(1)-(6) Drug Regin Drugs §483.45(d) Unnecessary Dr Each resident's drug regime unnecessary drugs. An unnwhen used- §483.45(d)(1) In excessive therapy); or §483.45(d)(2) For excessive §483.45(d)(3) Without adeq §483.45(d)(4) Without adeq §483.45(d)(5) In the present which indicate the dose sho discontinued; or §483.45(d)(6) Any combina paragraphs (d)(1) through (5) This REQUIREMENT is not	ugs-General. n must be free from ecessary drug is any drug dose (including duplicate duration; or quate monitoring; or quate indications for its use of adverse consequently described by the reduced or attions of the reasons states of this section.	g e drug use; or ces		The facility will ensure reside have appropriate diagnosis of administration of antipsychomedications. Resident R63 I medication will be reviewed physician, and if indicated, a appropriate diagnosis will be for the continued use of the medication, or the medication discontinued. A house audit will be complevalidate residents ordered the antipsychotic medication Hahave an appropriate diagnosiuse. The Director of Nursing or I will re-educate licensed nursincluding new hires and agenthe facility policy and proceed medication administration, densuring appropriate diagnost the use of Haldol an antipsycomedication. The Director of Nursing or I will complete an audit week	or the or	Completion Date: 05/23/2023 Status: APPROVED Date: 04/28/2023
					four weeks then monthly for		1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		A. BLDG: _	(X3) DATE SUR' COMPLETED: (D0			
	VIDER OR SUPPLIER:	395295	STREET ADDRESS,	CITY, STATE, Z	TIP CODE:	V 1/ 1// HVHU		
	VILLE REHABILITATION SS CENTER	AND	3300 LOGANS MURRYSVIL					
STATE LICENS	E NUMBER: 134702							
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DEI ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0757	Continued from page 25			F 0757				
SS=D					months to validate residents the appropriate diagnosis for of Haldol. The results of these audits wiforwarded to the monthly Qu Assurance and Performance Improvement Committee for and frequency of audits.	the use		

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	ATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIE IDENTIFICATION NUMBER (XI) PROVIDER/SUPPLIE IDENTIFICATION N			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVI COMPLETED:	ΞΥ
		395295		A. BLDG:00 B. WING: 04/19/2023		04/19/2023	
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER SE NUMBER: 134702	N AND	STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	OAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D PREFIX MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0757	Continued from page 26	Continued from page 26					
SS=D	Based on review of factoreview, and staff interview, and staff interview the facility failed to adappropriate diagnosis of (Resident R63) Findings include: Review of facility policy reviewed 2/23/23, indicused antipsychotic drug drugs unless antipsychotic treat a specific condition documented in the clinical Review of Resident R6 (MDS - periodic assess 1/31/23, indicated the 16/11/20 and current diagrammental without behas thought processes causing impaired blood flow to schizophrenia (character)	riews, it was determinister medication for one of six resider by "Antipsychotic Deterministed residents who get therapy are not give therapy are not give tition as diagnosed and ical record. The same of care needs are sident was admitted agnosis included vas a viors (memory and ded by brain damage by your brain) paranoic	orugs" last have not ven these necessary and Set dated ad on cular other from ad				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER 395295			(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVEY COMPLETED: 04/19/2023		
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER	N AND	STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	COAD		
	E NUMBER: 134702	OF DEPLOYENCIES (FACULDE	PLOTENCY		I		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE	
F 0757	Continued from page 27		F 0757				
SS=D	positive symptoms of sidelusions and hallucinal pressure. Review of Resident R6 5/15/22, indicated Haloschizophrenia includin 1.5 milligrams was ord agitation. During an interview or Director of Nursing coproper diagnosis for H have an appropriate diagonal of an antipsychotic. 28 Pa. Code 201.14(a) 28 Pa. Code 211.2(a)Pa. 28 Pa. Code 211.9(a)(1.5)	ations), and high blo 63's physician order dol (manages symptog g hallucinations and lered two times a day a 4/19/23, at 11:47 a nfirmed that agitation aldol, and the facility agnosis for the admin	dated oms of delusions) y for .m. the on is not a y failed to nistration censee.				
	28 Pa. Code 211.12(d)	(1) Nursing services	L				
	: :	() - · · · · · · · · · · · · · · · · · ·	<u>-</u>				

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395295				04/19/2023		
NAME OF PROVIDER OR SUPPLIER: MURRYSVILLE REHABILITATION AND WELLNESS CENTER			STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	OAD			
STATE LICENSE NUMBER: 134702 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0761				F 0761				
SS=D								

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	OF DEFICIENCIES AND RECTION (POC)	identification number 395295		A. BLDG:	00	COMPLETED: 04/19/2023	ED:	
NAME OF PROVIDER OR SUPPLIER: MURRYSVILLE REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: 134702			STREET ADDRESS 3300 LOGAN MURRYSVII	S FERRY R	OAD			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ID BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0761 SS=D	Continued from page 29 483.45(g)(h)(1)(2) Label/Sto §483.45(g) Labeling of Drug Drugs and biologicals used accordance with currently as and include the appropriate instructions, and the expirat §483.45(h) Storage of Drug §483.45(h)(1) In accordance the facility must store all drug compartments under proper permit only authorized perso keys. §483.45(h)(2) The facility in permanently affixed compar drugs listed in Schedule II of Abuse Prevention and Conti- subject to abuse, except who package drug distribution sy stored is minimal and a miss detected.	gs and Biologicals in the facility must be la accepted professional pri accessory and cautionarion date when applicables and Biologicals with State and Federal ags and biologicals in lot temperature controls, and prince to have access to the facility uses single extens in which the quarting dose can be readily	labeled in nciples, y e. laws, ocked and che locked, ontrolled rug er drugs e unit ntity	F 0761	The facility will accurately Is medications in accordance wand federal regulations. The multi dose injector Saxenda opened in use Lantus injecto have been discarded and wer replaced with pens labeled was resident names. A house audit will be compleensure injector medication plabeled with resident names. The Director of Nursing or I will re-educate licensed nursincluding new hires and agenthe facility policy and processorage and labeling of medidetailing ensuring injector medication pens are labeled resident names. The Director of Nursing or I will complete an audit two times and additional complete an audit two times.	opened and the or pen re with the eted to ens are the opened and the or pen re with the eted to ens are the opened etes, and on the opened etes, and opened etes, and opened etes etes, and opened ete	Completion Date: 05/23/2023 Status: APPROVED Date: 04/28/2023	
	This REQUIREMENT is no	t met as evidenced by:			week for four weeks then me for three months to validate medication pens are labeled resident names and stored appropriately.	injector		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION: 00	(X3) DATE SURVEY COMPLETED:	
		395295		B. WING:		04/19/2023	
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER	NAND	STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	OAD		
STATE LICENSE NUMBER: 134702 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0761 SS=D	Continued from page 30			F 0761	The results of these audits w		
					forwarded to the monthly Qu Assurance and Performance Improvement Committee for and frequency of audits.		

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	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/ PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:			
		305305		A. BLDG: <u>00</u>		04/19/2023			
		395295				0 1/15/2020			
	VIDER OR SUPPLIER: /ILLE REHABILITATION	N AND	STREET ADDRESS, CITY, STATE, ZIP CODE: 3300 LOGANS FERRY ROAD						
	S CENTER	, 111,12	MURRYSVIL						
STATE LICENS	e number: 134702								
(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)		
PREFIX TAG		ED BY FULL REGULATORY OF FYING INFORMATION)	R LSC	PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	COMPLETE DATE		
mo		THIO IN ORDER			CROSS-REFERENCED TO THE	AFFROFRIATE	BATE		
F 0761	Continued from page 31		F 0761						
SS=D									
~~ -	Based on review of fac	ility policy, observa	tions, and						
	staff interview, it was o	determined that the f	acility						
	failed to accurately lab	el medications as re	quired in						
	one of five medication	carts (Cart 49)							
	Findings include:								
		u- 1 1: 03.5							
	Review of facility police	, .							
	indicated all medicatio		•						
	properly labeled in acc and federal regulations								
	containers must contain		•						
	containers must contain	ir the resident's name							
	During an observation	on 4/17/23, at 11:10	a.m. the						
	facility Medication Car	•							
	Saxenda (multi dose in								
	injects medicine just ur	nder the skin) injecto	or pen,						
	that failed to have a me	edication label with	a residents						
	name, and a open in us	e Lantus insulin (tre	ats						
	diabetes and injects lor								
	skin) injector pen that		ication						
	label with a residents n	ame.							

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	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/ PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER					(X3) DATE SURVEY COMPLETED:	
		395295		B. WING: 04/19/2023			
MURRYSV WELLNES	NAME OF PROVIDER OR SUPPLIER: MURRYSVILLE REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: 134702		STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	OAD		
(X4) ID				ID	PROVIDER'S PLAN OF CORREC	CTION (EACH	(X5)
PREFIX TAG		ED BY FULL REGULATORY OF FYING INFORMATION)	R LSC	PREFIX TAG	CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	COMPLETE DATE
F 0761	Continued from page 32			F 0761			
SS=D	D :	4/17/02 + 1.02	.1				
	During an interview on Director of Nursing con	-	n. the				
	observation, and that th		ave				
	medication labels with						
	injector pens, as require						
	28 PA Code 211.9: (a)(1)(h) Pharmacy ser		vices				
	28 PA Code 211.12: (1)(2) Nursing service	es.				
F 0812				F 0812			
SS=F							

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***************************************		IDENTIFICATION NUMBER		A. BLDG: _00_ B. WING:		(X3) DATE SURVEY COMPLETED: 04/19/2023	
MURRYS' WELLNES	IVIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER SE NUMBER: 134702		STREET ADDRESS 3300 LOGAN MURRYSVII	S FERRY R	OAD	0.137.2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		OULD BE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 33 483.60(i)(1)(2) Food Procurement, Store/Prepare/ §483.60(i) Food safety requ The facility must - §483.60(i)(1) - Procure food considered satisfactory by f authorities. (i) This may include food it producers, subject to applicate regulations. (ii) This provision does not from using produce grown is compliance with applicable practices. (iii) This provision does not consuming foods not procur §483.60(i)(2) - Store, preparaccordance with professions safety. This REQUIREMENT is not	d from sources approved dederal, state or local ems obtained directly frable State and local law prohibit or prevent facilin facility gardens, subjessafe growing and foodappreclude residents from the detail of the facility.	om local s or ities ect to handling	F 0812	The facility will ensure kitch equipment is maintained in a condition to prevent cross contamination in the main kit the facility. Facility immedia removed debris from fan cover the ceiling in walk-in cooler main kitchen when identified surveyor on 4/16. Maintenance inspected facility other walk-in cooler and free validate that the fan covers a ceilings were free from debrial debrace dietary staff on facility's "Sanitation" policy outlines the requirement to relate the equipment in a sanitation condition to avoid cross-contamination. The administrator or designed complete an audit 5x weekly weeks and then weekly for the months to validate that the factorers and ceilings in the fact walk in cooler and freezer and	itchen of ately vers and of the d by ity's ezer to and is. esignee the which nain ary	Completion Date: 05/23/2023 Status: APPROVED Date: 04/28/2023

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395295				04/19/2023	
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER E NUMBER: 134702	I AND	STREET ADDRESS, 3300 LOGAN; MURRYSVIL	S FERRY R	OAD		
(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORREC	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE IDENTII	R LSC	PREFIX TAG	CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	COMPLETE DATE	
F 0812	Continued from page 34			F 0812			
SS=F					from debris.		
					The results of these audits w		
					forwarded to the monthly Qu Assurance and Performance	-	
					Improvement Committee for and frequency of audits.	review	
				•			· ·

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***************************************		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: (X3) DATE SUF COMPLETED: A. BLDG: 00		(X3) DATE SURVI COMPLETED:	ΕY
		395295		B. WING: 04/19/2023			
NAME OF PROVIDER OR SUPPLIER: MURRYSVILLE REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: 134702			STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	OAD	I	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0812	Continued from page 35			F 0812			
SS=F	Based on a review of printerview, it was determined in the modern properly maintain kitch condition creating the contamination in the modern properly maintain kitch condition creating the properly maintain in the modern properly maintain in the modern properly in the modern	mined that the facility and equipment in a suppotential for cross that anitation policy data food service area shad and sanitary manner. I made on 4/16/23, at oler in the designate revealed that cold air and the ceiling immer fans had a build-up adde on 4/16/23, at 10 ok Employee E2 confan covers and the ceiling fans had a build-up fans had a build-up adde on 4/16/23, at 10 ok Employee E2 confan covers and the ceiling fans had a build-up fans fans fans fans fans fans fans fans	y failed to anitary cility. ed, all be 10:20 d main diately of dust, 0:20 diffrmed reiling				

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	NT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/CI CORRECTION (POC) IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		205205			00	04/19/2023	
		395295				0 1/15/2020	
	VIDER OR SUPPLIER: V ILLE REHABILITATION	N AND	STREET ADDRESS, 3300 LOGANS				
	S CENTER		MURRYSVIL	LE, PA 150	668		
STATE LICENS	E NUMBER: 134702						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE				ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG		ED BY FULL REGULATORY O FYING INFORMATION)	R LSC	PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A		COMPLETE DATE
F 0812	Continued from page 36			F 0012			
Г 0812	Continued from page 30			F 0812			
SS=F							
	built-up of dust, grime,	, and debris.					
	D :	1 4/17/22 + 14	0.10				
	During an interview man, Regional Dietitian						
	the facility failed to ma						
	equipment creating the		iitai y				
	contamination in the M	-					
	28 Pa. Code: 201.14(a)	Responsibility of li	censee.				
	28 Pa. Code: 201.18(b)	(1) Management.					
	28 Pa. Code: 211.6(c) 1	Dietary services.					
F 0847				F 0847			
SS=D							

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	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			PLE CONSTRUCTION:	(X3) DATE SURV COMPLETED:	ΈΥ
		395295			00	04/19/2023	
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER SE NUMBER: 134702	N AND	STREET ADDRESS. 3300 LOGAN MURRYSVII	S FERRY R	OAD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0847	Continued from page 37			F 0847			
SS=D	483.70(n)(2)(i)(ii)(3)-(5) Er Agreements §483.70(n) Binding Arbitra If a facility chooses to ask a representative to enter into a arbitration, the facility must requirements in this section §483.70(n)(1) The facility n his or her representative to a representative to sarbitration as a condition of requirement to continue to r must explicitly inform the re representative of his or her as a condition of admission continue to receive care at, to	tion Agreements resident or his or her an agreement for binding comply with all of the nust not require any resi sign an agreement for bi admission to, or as a receive care at, the facili resident or his or her right not to sign the agree to, or as a requirement to	g dent or nding ty and eement		The facility will ensure reside have the capacity to understaterms of a binding agreement signing the paperwork. The will destroy the arbitration agreement signed by Resider the facility will review and ethe arbitration agreement to resident representative. The facility will complete a laudit and review existing resarbitration agreements to valusigned by a resident they have capacity to understand the tethe agreement.	and the t before facility nt R244, explain the house sident lidate if we the	Completion Date: 05/23/2023 Status: APPROVED Date: 04/28/2023
	§483.70(n)(2) The facility n (i) The agreement is explair representative in a form and understands, including in a or her representative unders (ii) The resident or his or he that he or she understands the \$483.70(n)(3) The agreement resident or his or her representations of the presentation of the presen	need to the resident and he manner that he or she language the resident and tands; or representative acknown agreement; on the must explicitly grant tentative the right to resc	d his rledges the		The Nursing Home Adminis Designee will re-educate the Admissions Director on the regulation 0847 and the requ for entering into arbitration agreements, detailing ensurin residents have the capacity to understand the terms of the agreement. The Nursing Home Adminis Designee will complete an a	Federal irrements ing the o	

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395295		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 04/19/2023	ΞY
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER E NUMBER: 134702		STREET ADDRESS, 3300 LOGAN; MURRYSVIL	S FERRY R	OAD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0847 SS=D	\$483.70(n) (4) The agreement nor his of the sign an agreement for bin of admission to, or as a requester at, the facility. \$483.70(n) (5) The agreement language that prohibits or dranguage that pro	or her representative is redding arbitration as a contirement to continue to rent may not contain any iscourages the resident ocating with federal, state imited to, federal and state health department we of the Office of the San, in accordance with	equired ndition receive or e, or local ate	F 0847	weekly for four weeks then refor three months to validate facility is complying with the regulation for Arbitration Agreements and that the resistance the capacity to understaterms of the agreement. The results of these audits we forwarded to the monthly Quantum Assurance and Performance Improvement Committee for and frequency of audits.	the e idents and the rill be uality	

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			PLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED:	ΞΥ
		395295		A. BLDG: _ B. WING: _		04/19/2023	
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER E NUMBER: 134702	N AND	STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	OAD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFI MUST BE PRECEEDED BY FULL REGULATORY OR IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0847	Continued from page 39			F 0847			
SS=D							
	Based on review of fac						
	clinical record and staf						
	was determined that the	<u>-</u>					
	resident had the capacity to understand the terms of a binding arbitration agreement for one of three						
	residents (Resident R2		шисс				
).					
	Findings include:						
	Review of Resident R2	244's admission Min	imum				
	Data Set dated 4/19/23	, indicated she was a	admitted				
	on 4/13/23, and her Bri	ief Interview for Me	ntal				
	Status Score (BIMS - t	est of cognitive abil	ity) score				
	was 3 (indicated severe	e cognitive impairme	ent).				
	Review of Resident R2						
	she has current diagnos						
	(progressive disease th	3					
	other important mental urinary tract infections	**	and				
	Review of Resident R2 Agreement (a binding a	•					

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBER			IPLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY
		395295				04/19/2023	
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER SE NUMBER: 134702	N AND	STREET ADDRESS, 3300 LOGAN; MURRYSVIL	S FERRY R	COAD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0847	Continued from page 40			F 0847			
SS=D	submit to arbitration al have arisen or may arise a defined legal relation not. The decision is fin court, and can only be grounds) indicated she admission on 4/13/23. During an interview or the Social Worker Emp R244, the resident was could not recall signing Worker Employee E14 baseline cognitive state. During an interview or Admission Director Erfacility failed to ensure capacity to understand arbitration agreement. 28 Pa. Code 201.24 (b)	se between them in raship, whether contrall, can be enforced appealed on very na signed the document of 4/19/23, at 8:53 a.r. ployee E14 and Residual confused at baseling any paper work. The confirmed this was as as a 4/19/23, at 9:00 a.r. mployee E15 confirmed resident R244 had the terms of a bindi	respect of actual or by a actual or by a actual or actual or actual or by a actual or				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395295			A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 04/19/2023	ΣΥ	
MURRYSV WELLNES	vider or supplier: /ILLE REHABILITATION SS CENTER e number: 134702	N AND	STREET ADDRESS, 3300 LOGANS MURRYSVIL	FERRY R	OAD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIEN MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0847 SS=D	Continued from page 41			F 0847			
	28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(2) Management						
	28 Pa. Code 201.18(b)(28 Pa. Code 201.29(a)(

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:				(X3) DATE SURVE COMPLETED:		
		395295			B. WING: 04/19/2023			
NAME OF PROVIDER OR SUPPLIER: MURRYSVILLE REHABILITATION AND WELLNESS CENTER STREET ADDRESS, CITY, STATE, ZIP CODE: 3300 LOGANS FERRY ROAD MURRYSVILLE, PA 15668								
	E NUMBER: 134702				T			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCE MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
P 1600				P 1600				
LABORATORY	DIRECTOR'S OR PROVIDER/SUPPLI	ER REPRESENTATIVE'S SIGN	ATURE		TITLE:	(X6) DATE:		
							_	

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTI	LTIPLE CONSTRUCTION: (X3) DATE SURVEY COMPLETED:		EY
		395295				04/19/2023	
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION SS CENTER DE NUMBER: 134702	N AND	STREET ADDRESS. 3300 LOGAN MURRYSVIL	S FERRY R	OAD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
P 1600	Continued from page 1 § 209.8(b) Fire Drills. (b) A written report shawhich includes date, time rerelocation, number of reside another location and number fire drill. This REGULATION is not	equired for evacuation or ents evacuated or moved or of personnel participat	r I to	P 1600	The facility will accurately rewritten fire drill reports that include time required for eva or relocation of residents. The facility cannot retroactively the concerns identified durin survey. The facility immediately reverse drill form to include time for evacuation or relocation or residents. The Nursing Home Administ Designee will re-educate the Maintenance Director on Residents and maintaining fire drill that include time required for evacuation or relocation of residents. The Nursing Home Administ will review the fire drill logs for four months to validate the required time for evacuation relocation of residents is documented. The results of these audits we will review the fire drill form the results of these audits we will review the fire drill form the results of these audits we will review the fire drill form the results of these audits we will review the fire drill form the results of these audits we will review the fire drill form the results of these audits we will review the fire drill form the results of these audits we will review the fire drill form the results of these audits we will review the fire drill form the results of these audits we will review the fire drill form the results of these audits we will review the fire drill form the results of these audits we will review the fire drill form the review the fire drill f	will acuation ac acuation ac acuation ac acuation ac acuation acc acc acc acc acc acc acc acc acc ac	Completion Date: 05/23/2023 Status: APPROVED Date: 04/28/2023

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Pennsylvania Department of Health

		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395295		A. BLDG: _ B. WING: _	<u>00</u>	04/19/2023	
MURRYSV WELLNES	VIDER OR SUPPLIER: VILLE REHABILITATION S CENTER E NUMBER: 134702	I AND	STREET ADDRESS, 3300 LOGANS MURRYSVIL	S FERRY R	OAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
P 1600	Continued from page 2			P 1600	forwarded to the monthly Qu	ıality	
					Assurance and Performance Improvement Committee for and frequency of audits.		

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	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/GIDENTIFICATION NUMBER 395295			PLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED: 04/19/2023	EY
MURRYS' WELLNE	OVIDER OR SUPPLIER: VILLE REHABILITATIO SS CENTER	N AND	STREET ADDRESS 3300 LOGAN MURRYSVII	S FERRY R	OAD		
	SE NUMBER: 134702	T OF DEFICIENCIES (FACH DE	FIGUENCY	ID			(V5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENC MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	PROVIDER'S PLAN OF CORR CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE
P 1600	Continued from page 3			P 1600			
	Based on review of the staff interview, it was failed to accurately matched to increase that are required to increase (April, May, June, Jul October, November, I February, and March 2 Findings Include: A review of facility per and Emergency Preparent indicated the facility was failed.	determined that the faintain written fire diclude the time require on for twelve of twely, August, September 2022, Janua 2023.)	facility rill reports ed for ve months r, ary,	F 1000			
	Review of the Fire Alarm Reports did not includocumentation to indicate the time required for evacuation or relocation during the twelve mor reviewed, April 2022 through March 2023.		d for months				
	During an interview o Nursing Home Admir facility did not record relocation for twelve of	nistrator confirmed the time for evacuation	at the				

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Certified End Page

MURRYSVILLE REHABILITATION AND WELLNESS CENTER

STATE LICENSE NUMBER: 134702 SURVEY EXIT DATE: 04/19/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY